Pharmacy

Prior Authorization Criteria for Nuvigil (armodafinil)

Background

Armodafinil (Nuvigil) is a single R-enantiomer of modafinil (Provigil), and is approved by the FDA for improving wakefulness in patients with excessive sleepiness associated with obstructive sleep apnea or hypopnea syndrome (OSA/HS), narcolepsy, and shift work sleep disorder (SWSD). Modafinil (Provigil) has the same FDA-approved indications.

The following criteria were established by the DoD Pharmacy & Therapeutics (P&T) Committee. The effective date for this prior authorization is 30 December 2009. This prior authorization approval is good for 1 year.

Prior Authorization Criteria for Nuvigil (armodafinil)

All current and new users of Nuvigil (armodafinil) must meet one of the following criteria in order for Prior Authorization to be approved:

Coverage provided for the use of armodafinil treatment of:

- Excessive daytime sleepiness associated with narcolepsy diagnosed by polysomnogram or mean sleep latency time (MSLT) objective testing
- Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSA/HS), only after adequate titration of continuous positive airway pressure (CPAP) treatment
- Excessive sleepiness associated with shift-worker sleep disorder (SWSD), only in patients who work night shifts

Additionally, patients must have had a trial of provigil (modafinil) before receiving PA approval for Nuvigil (armodafinil).

NOTE: this prior authorization is not intended to apply to armodafinil use in active duty operational/readiness situations based on established protocols; Military Treatment Facilities should make necessary allowances for such use.

Coverage NOT provided for the use of armodafinil (Nivigil) for the treatment of other conditions, including:

- Excessive fatigue associated with multiple sclerosis
- Excessive fatigue associated with myotonic dystrophy Depression
- Idiopathic hypersomnia
- Chronic fatigue syndrome
- Stroke rehabilitation
- Appetite suppression
- Parkinson's disease

Criteria approved through the DoD P&T Committee process

TRICARE Prior Authorization Request Form for **Nuvigil** (armodafinil)

5599

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TPharmPA@express-scripts.com**

Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php. This prior authorization is effective for 1 year.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. What is the indication or diagnosis? Document the indication or diagnosis and **proceed to Question 2**		
2. Has the patient tried modafinil (Provigil)?	☐ Yes Proceed to question 3	☐ No **Coverage not approved**
3. Does the patient meet BOTH of the following criteria? • A diagnosis of excessive daytime sleepiness associated with **narcolepsy**. • Narcolepsy was diagnosed by polysomnogram or mean sleep latency time (MSLT) objective testing.	☐ Yes **Sign and date below**	☐ No **Proceed to question 4**
4. Does the patient meet BOTH of the following criteria? • Excessive daytime sleepiness associated with **obstructive sleep apnea/hypopnea syndrome (OSAHS)**. • The patient has had adequate titration of continuous positive airway pressure (CPAP) treatment.	☐ Yes **Sign and date below**	☐ No **Proceed to question 5**
5. Does the patient meet BOTH of the following criteria? • Excessive sleepiness associated with **shift-worker sleep disorder (SWSD)**. •The patient works night shifts.	☐ Yes **Sign and date below**	☐ No **Coverage not approved** †

† Coverage is NOT provided for the treatment of other conditions not listed above, including: jet lag, excessive fatigue associated with multiple sclerosis, excessive fatigue associated with myotonic dystrophy, depression, idiopathic hypersomnia, fatigue associated with traumatic brain injury, chronic fatigue syndrome, stroke rehabilitation, appetite suppression, Parkinson's disease.

Step 3 **I certify the above is true to the best of my knowledge.**

Please sign and date:

_____ _____

Prescriber Signature Date